[illegible] INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 816 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$1500.00	4	97						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 5-6 1997 Signed Christopher Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

FAXED 6-2-97

...LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 5166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
1000.00	5	97						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 6-2 19 97 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

[illegible] INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493629

1. I was residually disabled from 2/8 19 93 to present 19 .

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 .

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 5166 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$ 1500	6	97						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 7-8-12 19 97 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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[illegible] LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 816 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
1500	6	97						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 7-8-12 19 97 Signed Christopher L. Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

[illegible] LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 816.6 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
1000.00	7	97						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 8-6 1997 Signed Christopher Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

...LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation_____

_____

_____or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 45 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 516.6 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B)___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$1500.00	[redacted]8	97						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date [redacted] 8-26 1997 Signed Christopher Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L KEARNEY Date of Birth 11-9-52
Policy No. H 493021 + H 53806

1. I was residually disabled from 2-8 19 93 to Present 19___.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation_____
_____
_____ I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

4. I was under the care and attendance of a physician from_____ 19___ to _____19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8766 (to the nearest dollar.)

I used the ✓ prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
1000.00	9	97						

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date 9-15 19 97 Signed Christopher Kearney
(Claimant)

_____
(Street Address) (City or Town) (State)

_____(Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

INDIVIDUAL HEALTH CLAIMS (41 17)

SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Date of Birth 11-9-52
Policy No. H 493025 + H 538046

1. I was residually disabled from 2-8 19 93 to Present 19 ___.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation _____ _____ I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

4. I was under the care and attendance of a physician from _____ 19 ___ to _____ 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the ✓ prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
1000	10	97						

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date 9-30-97 Signed Christopher L Kearney
(Claimant)

12168 VILLAGE WOODS CINCINNATI OH
(Street Address) (City or Town) (State)

_____ (Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

INDIVIDUAL HEALTH CLAIMS (417)

SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER KEARNEY Date of Birth 11-9-52
Policy No. H 493025 + H 53806

1. I was residually disabled from 2/6 19 53 to present 19 ___.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation _____
_____ I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not now 19 ___.

4. I was under the care and attendance of a physician from 2/8/93 one 19 ___ to present 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the ✓ prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$1000.00	11	97						

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date 11-29 19 97 Signed Christopher Kearney
(Claimant)

(Street Address) (City or Town) (State)

(Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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INDIVIDUAL HEALTH CLAIMS (1977)

SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER KEARNEY Date of Birth 11-9-52
Policy No. H 493025 + H 538046

1. I was residually disabled from 2-93 19__ to present 19__.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation_____
_____ I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on NOT SURE 19__.

4. I was under the care and attendance of a physician from 2-93 19__ to present 19__.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the ✓ prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
1000.00	12	97						

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date 1-2 19 98 signed Christopher Kearney
(Claimant)

12168 VILLAGE WOODS CINCINNATI OH
(Street Address) (City or Town) (State)

45241 (Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

INDIVIDUAL HEALTH CLAIMS (1-77)

SUPPLEMENTAL CLAIMANT'S STATEMENT

For

RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Date of Birth 11-9-52

Policy No. H 493025 + H 53806

1. I was residually disabled from _____ 19___ to _____ 19___.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation_____ _____ I was able to perform all of the usual daily business duties of my occupation, but only for 45 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19___.

4. I was under the care and attendance of a physician from 1993 19___ to present 19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the ___ prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
$0	1	98						

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date 2-2- 19 98 Signed Christopher Kearney (Claimant)

12168 VILLAGE WOODS DR, CINCINNATI, OH

(Street Address) (City or Town) (State)

45241 (Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

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INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER KEARNEY Date of Birth 11-9-52
Policy No. H 493025 + H 538046

1. I was residually disabled from 1993 19__ to Present 19__.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation_____
_____ I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19__.

4. I was under the care and attendance of a physician from 1993 19__ to Present 19__.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the ___ prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
0	2	98						

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date 3-2 1998 Signed Christopher L Kearney
(Claimant)

12168 VILLAGE WOODS DR CINCINNATI OH 45249
(Street Address) (City or Town) (State)

45241 (Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

98 MAR -4 AM 11:04

INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER L. KEARNEY Date of Birth 11/9/52
Policy No. H 493015 + H 538046

1. I was residually disabled from 1993 19__ to present 19__.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation_____
_____ I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19__.

4. I was under the care and attendance of a physician from 1993 19__ to present 19__.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the ___ prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
0	3	98						

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date 4-1 19 98 Signed Christopher L. Kearney
(Claimant)

12168 Village Woods Dr. Cincinnati OH
(Street Address) (City or Town) (State)

45241 (Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

93 APR -6 AM 9:21

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INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT
For
RESIDUAL DISABILITY BENEFITS

Name in Full CHRISTOPHER KEARNEY Date of Birth 11-9-52
Policy No. H 493025 + H 538046

1. I was residually disabled from _____ 19___ to present 19___.

2. During this period of residual disability I was unable to perform the following important daily business duties of my occupation_____
_____ I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on Not sure 19___.

4. I was under the care and attendance of a physician from_____ 19___ to _____19___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 5 AND 6, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUITIES OR OTHER FORMS OF UNEARNED INCOME.

5. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 8166 (to the nearest dollar.)

I used the ✓ prior calendar year ___ prior twelve consecutive months earnings to determine this average.

6. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
0	~~4~~ 4	98						

Any information necessary to verify the answers I have given above will be furnished upon receipt.

Date 5-1 19 98 Signed Christopher Kearney
(Claimant)

12168 Village Woods Dr. Cincinnati OH
(Street Address) (City or Town) (State)

45241 (Zip Code)

PLEASE ATTACH THIS FORM DIRECTLY TO THE SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

...LIFE INSURANCE COMPANY
INDIVIDUAL HEALTH CLAIMS (417)
SUPPLEMENTAL CLAIMANT'S STATEMENT -
For
RESIDUAL DISABILITY BENEFITS

H-538069

Name in Full CHRISTOPHER KEARNEY Policy No. H-493029

1. I was residually disabled from 2/8 19 93 to present 19 ___.

2. During this period of residual disability I was (A) unable to perform the following important daily business duties of my occupation _____

_____

_____ or (B) I was able to perform all of the usual daily business duties of my occupation, but only for 65 % of the time usually required to perform these duties.

3. I expect to return to the full performance of my occupation on not sure 19 ___.

NOTE: FOR PURPOSES OF ANSWERING QUESTIONS NO. 4 AND 5, INCLUDE MONTHLY INCOME FROM SALARY, WAGES, BONUSES, COMMISSIONS, FEES OR OTHER REMUNERATION, AFTER DEDUCTION OF NORMAL AND CUSTOMARY BUSINESS EXPENSES BUT BEFORE DEDUCTION OF ANY INCOME TAXES, EARNED FOR SERVICES PERFORMED BY YOU. DO NOT INCLUDE DIVIDENDS, RENTS, ROYALTIES, ANNUNITIES OR OTHER FORMS OF UNEARNED INCOME.

4. My average monthly income for the calendar year or the twelve consecutive months immediately prior to my period of total disability (the greater) was $ 816.6 (to the nearest dollar.)

I used the (A) ✓ prior calendar year (B) ___ prior twelve consecutive months earnings to determine this average.

5. My monthly income for each month for which claim is being made is as follows:

Amount	Month	Year	Amount	Month	Year	Amount	Month	Year
0	5	98						

Any information necessary to verify the answers I have given above will be furnished upon request.

Date 6-2 19 98 Signed Christopher Kearney
(Claimant)

PLEASE ATTACH THIS FORM DIRECTLY TO A FULLY COMPLETED SUPPLEMENTAL DISABILITY CLAIM REPORT - BE SURE TO SIGN THE DISCLOSURE AUTHORIZATION ON THE BACK OF THAT FORM.

0900